

Issue Date: December 7, 2001
Closing Date: January 7, 2002
Closing Time: 12:00 EST

SUBJECT: Quality Assurance and Workforce Development

Ladies/Gentlemen:

THIS IS NOT A REQUEST FOR PROPOSAL. USAID is preparing for issuance of a Request for Proposals (RFP) for the subject program. USAID is soliciting comments from interested parties, in order to further refine this Draft Scope of Work (DSOW). This procurement will be a full and open competition. Your comments will be appreciated and considered as we finalize the RFP for the proposed contract. No information on Pricing, Competition, Instructions to Offerors or Evaluation Criteria is available at this time.

Answers to the questions will be posted in the Solicitation (contractors will not be identified with the question). Comments may or may not be incorporated in the Statement of Work. Comments will be accepted until January 7, 2002, 12:00 EST. All comments shall be addressed to Charity Benson in writing at (Email preferred: cbenson@usaid.gov), fax: 202-216-3396, or by mail addressed: USAID, 1300 Pennsylvania Ave., Attn: Charity Benson, M/OP/G/PHN, RRB 7.9.141, Washington, DC 20523.

Thank you for your interest.

Sincerely,

Emmanuel E. Atsalinos
Contracting Officer

Statement of Work for Quality Assurance and Workforce Development

Summary: This statement of work describes the technical content of a five year, \$48 million contract to be procured by the USAID Bureau for Global Health, Office of Health and Infectious Disease. It is divided into the following sections:

- A. Background for the procurement
- B. Description of the problem the contract shall address
- C. A summary of the approach to the problem
- D. Relationship to USAID mission strategic objectives
- E. Outline of the components of the field of quality assurance
- F. Outline of the components of workforce development
- G. Objectives of the contract
- H-K. Other information on the contract

- A. Background: The contractor shall develop a program that continues to adapt quality assurance (QA) approaches to the needs of USAID-assisted countries through 1) long-term support for the development of institutionalized QA programs; 2) short-term technical assistance in the full range of modern QA methodologies; 3) a program of operations research; and 4) providing technical leadership in the application of QA. This program will continue and expand the program developed under the current QA contract [HRN-C-00-96-90013-00.] The major products of this contract can be found at www.qaproject.org. USAID will provide a recent version of this web site as a CD-ROM upon request. The selection for long-term countries for this contract will depend on field support funding provided by USAID missions and regional offices. Based on historical patterns and current USAID policies, the Mission with substantial financial commitment to QA or recent expressions of interest: include Russia, Jamaica, Bolivia, Eritrea, Ethiopia, Rwanda, Zambia, South Africa, Nicaragua, Honduras, Bangladesh.

The contractor shall, in addition, extend the technical content from USAID's current contract of the current QA program to address issues related to workforce development and the management of human resources in health programs, as described below.

- B. The problem that this contract will address: The most common strategy for measuring quality of care is to compare what providers actually do, with a standard for what they should do. The standard applied should reflect the best available evidence and allow for what is feasible. The basic services that USAID programs emphasize are well suited for these measurements. Integrated Management of Childhood Illness (IMCI) illustrates an evidence-based standard, and similar standards apply to many other services. Over the past several years, there has been a strong global trend to look at health care in terms of

objective standards. As programs begin to define how health workers should perform, we are learning the logical implications of this fundamental change in perspective.

A growing number of evaluations have produced a consistent impression of the challenge developing country health programs face related to quality of care:

- Most assessments show serious and widespread quality problems: A prominent example is a series of WHO surveys in 17 child health programs that showed that on average, only about 30% of children with pneumonia received adequate care. "Adequate" care was defined in terms of carrying out most of the key tasks for assessing the child, prescribing the correct treatment, and providing counseling and follow-up messages. Using a more rigorous methodology, a recently published study in Burkina Faso (G. Krause, et al, International J. for Quality in Health Care, 2000; Volume 12, No. 1: pp. 25-30) found that only 2% of general clinic patients met minimal standards for assessment and treatment. These and a large number of similar quality assessments consistently identify serious and widespread deficiencies in quality of both preventive and curative services. Quality of care is a major issue for each of USAID's priorities in health.
- These low levels of quality imply limited health impact and wasted resources: Health care that follows standards 30% of the time may have a health impact somewhat higher or lower than 30% of expected, but it clearly indicates a basic inability of a health program to set a goal and then meet it. Further, studies confirm a direct relationship between following a quality standard and reduced mortality (T. Amed, et al, The Lancet Volume 353, June 5, 1999; pp. 1919-1922).
- Health systems are not identifying and dealing with these quality problems: The most obvious impediment is that few programs actually monitor quality--virtually all quality assessments are external. But concrete responses to quality problems are also lacking. Supervisory systems are in place, but their role in quality is rarely well defined.
- Established assistance strategies are having only limited impact: A recent review of mission R-4 reports showed that efforts to improve quality are dominated by training. However, one of the clearest findings of research in this field is that such training has only a limited impact on what providers actually do: Many obstacles to performance have little to do with the providers' technical knowledge.
- Quality of care challenges are becoming more difficult: A number of emerging health problems require care that is more demanding of providers, such as AIDS-related care, resistant malaria, and behavior change counseling. Performance at 30% of standards in these areas could prove not just ineffective, but harmful.

Weaknesses in workforce development or human resources management (HRM) add to these problems. The principles that apply to managing the personnel of a large organization are well established, but appear to be broadly neglected in developing country health systems. Donor involvement has also been limited, and there are few experienced consultants globally.

Recent reviews, however, suggest that the typical health system pays a high price for current HRM practices, even though the costs are difficult to measure. For example, a 1998 assessment in Angola revealed that nearly 10% of the salaries paid by the MOH

went to fraudulent "ghost workers." For the most part, however, there is very little research and evaluation focused on HRM in developing country health systems. There is broad agreement on the common problems, but little objective evidence to support concrete solutions. Examples of HRM issues include:

- Staff can avoid undesirable posts through political favors and other informal means, limiting access to care in rural areas
- Although salary costs are predictable, payment is irregular, lowering motivation
- The actual performance of staff is not assessed or managed, foregoing a basic improvement strategy
- Many staff have no prospects for career development, regardless of performance, eliminating a critical, long-term incentive
- Rigid terms of employment rule out part-time and contract workers, lowering efficiency
- Educational institutions graduate students without regard to health system needs, wasting training resources
- Decentralization moves forward without provision for new management skills, creating long-term inefficiencies
- Managers are unable to deploy the best mix of skills and types of workers, creating bottlenecks.

Efforts to change these entrenched systems entail risk of failure. However, successful HRM interventions offer the potential of long-term improvements that will benefit every program from AIDS to EPI. The contractor shall support a research and evaluation strategy that emphasizes developing an evidence base for HRM changes. This evidence should strengthen the case for broader, but difficult, reforms in HRM practices. The contractor shall also provide technical assistance in HRM, with an emphasis on human resources issues with a direct connection to quality of care.

- C. Overview of the approach that the contractor shall develop: There is a large and dynamic body of knowledge that deals with understanding how health care works and how it can be improved. The US has led a global movement in this area, introducing modern quality assurance about 30 years ago, incorporating industrial quality management approaches over the past 10 years, and more recently, merging these fields with evidence-based medicine and reduction of medical errors. Additional contributions come from the field of human performance technology, competency-based training innovations, and improved strategies for regulating care through external bodies.

As outlined below, the QA Project has assisted developing country programs to adapt these approaches to their needs. There is a large and growing body of experience that confirms the effectiveness of QA methodologies in a wide range of developing country health systems. Examples of such QA applications can be found in the previously cited web site, as well as in the reports of other USAID cooperating agencies and the published literature.

The contractor shall continue to offer specialized technical expertise in the full range of these approaches. In order to institutionalize the process of improvement, the contractor shall also continue to support the organization of sustainable QA programs as a new element in health systems. As a distinct set of activities, QA can be evaluated and held accountable for the resources it uses and the results it produces. Like programs in US medical centers, the QA programs that will be supported by this contract, will be carried out primarily by regular health staff. The major cost of QA activities is the time of these providers. Investment of scarce resources in QA must be justified by the improvements it produces. To achieve this accountability, it must be feasible to measure both the cost and the benefits of QA activities.

Collectively, the tools and approaches of the QA field may be termed "improvement" knowledge. More familiar areas of expertise in areas such as tuberculosis or maternal health, constitute "content" knowledge. Contractor assistance will include collaboration with the corresponding content experts, but quality assurance merits a distinct technical specialization, which the contractor shall provide. Through such collaborations, or through the content expertise of its staff and consultants, the contractor shall emphasize assistance in USAID health priorities. These priorities include: 1) reproductive health and family planning; 2) basic child survival and nutrition services; 3) essential obstetrical and neonatal care; 3) the prevention and mitigation of HIV/AIDS; and 4) control of major infectious diseases, particularly malaria and tuberculosis.

The management of human resources overlaps with the field of QA, but has received little attention from donors. Here again, R-4s indicate that most mission initiatives in HRM focus on provider training. Since labor typically represents about 75% of health care costs, how human resources are managed merits broader attention, extending beyond training.

Some of the more familiar HRM issues can be partially addressed by local quality improvement interventions, such as: 1) workers are not held accountable for scheduled hours, 2) low levels of motivation, and 3) work processes that do not make effective use of different kinds of staff. But since these are system-wide problems, there are advantages to addressing them at a higher level, where the policies are developed. Other widely recognized problems can be addressed only by dealing directly with HRM policy makers, such as: 1) lack of coordination among training institutions and service delivery, 2) job descriptions that do not respond to current needs, 3) chronically unfilled positions, and 4) dysfunctional systems for setting and paying salaries.

Labor issues are highly politicized however, and this has broadly reduced donor interest. Most improvements require the support of policymakers. Health system leaders may now be more open to HRM assistance than before, for several reasons:

1. The growing impact of HIV/AIDS in many countries is putting stress on health personnel in several ways.
2. Increased attention to quality of care is raising HRM issues such as motivation and performance management.
3. An overall trend toward holding governments and institutions accountable for their stewardship of resources also focuses attention on HRM, which represents most of those resources.

However, the argument for dealing with human resource issues has been limited by the scarcity of evidence that following HRM best practices produces concrete benefits. The contractor shall therefore develop a program in HRM that focuses on expanding the evidence base for these practices. This research and evaluation strategy shall emphasize small-scale trials of fairly narrow elements of HRM, rather than comprehensive, large-scale reform. These studies will focus on demonstrating changes in the quality and efficiency of care as a result of an HRM intervention. With limited resources available for this program, the contractor shall be required to focus on selected HRM issues, and will identify issues that are well suited to showing measurable improvements in the short term.

- D. Relationship to mission strategic objectives: Although the approaches of both QA and HRM are generic and apply to all health services, the contractor shall focus assistance on specific services when so requested by USAID missions providing funding.
- E. Components of Quality Assurance: There are seven major areas where modern quality assurance has proven useful for developing country health systems. The contractor shall provide qualified experts in each of these areas:
1. *Development of evidence-based guidelines*: If present trends continue, virtually every basic health service will be defined by a written guideline. These guidelines need to be well designed, and problems are already emerging. Health workers often regard certain guidelines as unclear, impractical or invalid-- and ignore them. There is a large body of knowledge that applies to such issues.
 2. *Monitoring quality of care*: Programs must be able to measure quality of care routinely, if they hope to improve it. Infrequent external evaluations do not obviate this basic management function. In addition to direct observation of care, several less expensive methodologies have shown promise: self-assessment, peer assessment, records audit, clinical vignettes, provider interviews, patient interviews, and surrogate patients. Specialized technical expertise will be needed to help managers develop practical systems for monitoring quality.
 3. *Promoting compliance with guidelines*: The success of different strategies to encourage providers to follow guidelines can be measured directly. The contractor shall offer managers support in evaluating several promising, but overlooked, approaches to support compliance, such as:
 - Endorsement by social peer groups and authorities
 - Human performance technology (job aids that incorporate state-of-the-art design techniques used in industry)
 - Performance-based feedback
 - Managed incentive systems (both material and symbolic)

Some of these approaches might be carried out through a traditional supervisory system. Provider training is currently the dominant strategy for promoting compliance with guidelines. The very large investment in classroom training by USAID (and other organizations) justifies an examination of alternatives. The contractor shall develop and evaluate innovative approaches that may be more efficient than traditional training for increasing compliance. The interactive,

computer-based training developed under the current QA contract will be further developed by the contractor, along with other training strategies.

4. *Problem solving/quality improvement:* Even the most diligent provider depends on others in the health system for support such as drugs and information. These "support systems" often perform poorly, even allowing for lack of resources. As we examine these problems, we find that the root causes vary widely with local circumstances. High levels of quality and efficiency probably require a program that can deal effectively with these unanticipated problems. A problem solving mentality is also needed to adapt to health reforms, like decentralization, and new health problems, like AIDS. As outlined in A Modern Paradigm for Improving Health care Quality (R. Massoud et al, The Quality Assurance Project, 2001), this has been an area of impressive progress in recent years. The contractor shall provide expert assistance in the full range of quality improvement methodologies:
 - Quality management: The industrial quality assurance strategies of Deming and others have worked well in health care, including extensive applications for problem solving in developing countries. Dozens of local teams have successfully applied this analytical approach in countries ranging from Niger to Russia. (These applications are illustrated in the case studies available in the previously cited web site for the Quality Assurance Project.) Continuing to adapt QM to developing country needs, will be a focus for contractor assistance.
 - Rapid problem solving: Growing experience with the analytical methods of QM suggests that many of the problems found in developing country health systems can be adequately addressed by simpler, less rigorous frameworks. The project will assist managers to develop efficient problem-solving strategies that make appropriate use of these techniques.
 - Benchmarking: Examples of local success in developing country QA interventions are difficult to replicate. Industrial QA has developed a systematic approach to capturing the lessons to be learned from outstanding performers. Benchmarking uses flow charts and other tools to describe the organization's processes--what different staff actually do. This type of detailed information is rarely available in ordinary program documents. A recent application of benchmarking in a group of US hospitals lowered surgical mortality by 24% (G. O'Connor et al, JAMA, March 20, 1996, Vol. 275, No. 11). The contractor shall use research and evaluation to adapt this approach to the needs of USAID-assisted health programs.
5. Re-design of systems of care: Health professionals are largely unaware that their services have an underlying design. Attempts to rationally organize service delivery may be flawed and incomplete to begin with, and are further compromised over time as the program adds new technologies and responds to changing health problems. The result can be services that show inherent inefficiencies when examined systematically. Shortcomings in the way health services are organized are easily overlooked, but can have a large impact over time.

For example, a QA Project assessment in Ecuador showed that long-standing procedures for admitting patients to the hospital, resulted in long delays in the treatment of obstetrical emergencies (See reports of the Latin America Maternal Mortality Initiative report in the cited web site.) In this case and many others, a local team was able to improve care by changing an old and non-functional design. A step-by-step methodology is available for such re-design efforts, and the contractor shall continue to refine and simplify it. Since most health systems were designed before HIV/AIDS, multi-drug resistant TB, IMCI, and large-scale behavior change communication, the contractor shall develop applications of re-design to such services.

6. Demand for quality, patient satisfaction and community input into care: Within the concept of quality of health care, it is common to distinguish between the perceptions of the patient or customer, and technical or scientific appropriateness. Techniques for monitoring patient satisfaction issues are well developed in the US. For developing countries, patient satisfaction has practical implications for utilization of services, willingness to pay, and compliance with treatment regimens. The level of interest of program managers in patient satisfaction has been limited, but appears to be increasing as health reform focuses attention on what consumers want. The contractor shall develop strategies and methods addressing this area that are suitable for developing country programs, addressing both measurement and improvement.

A related set of issues concerns an organized community role in the governance of local clinics. Here, too, most health systems have few initiatives, but interest seems to be growing. The contractor shall offer support for interested managers and policy makers in dealing with these unfamiliar issues, including development of research and evaluation activities.

The contractor shall also develop an overall research strategy to expand understanding of these and other factors in the demand for quality in health services.

7. Regulatory strategies: Policy makers have limited options for influencing the quality of care in the private sector, which is often much larger than the public sector. The regulatory approaches that are well-developed in industrial countries have been effectively overlooked by most developing countries. However, in recent years, a number of innovative regulatory programs have been launched and interest among policy makers continues to grow. The public sector has also been included in many of these initiatives, which include:

- *Accreditation:* In the most common model, an authoritative body periodically evaluates a facility according to pre-determined standards that have been published. The facility's rating is made public. The purpose is to provide an incentive to improve quality, but early experience suggests that most facilities also need assistance.
- *Certification:* This is typically a public recognition, usually for an individual, of advanced skills and knowledge in a specific area. Certification is based on standardized testing, a low cost strategy, but it remains uncommon in developing countries.

- *Licensing:* This is usually a governmental function. While most developed countries impose educational and re-testing requirements to maintain professional licenses, developing countries generally lack such requirements.
- *Insurance and reimbursement:* In developed countries, third party payment mechanisms commonly include specifications related to the quality of care that qualifies for reimbursement payments to private providers. As these financing schemes expand in developing countries, they will provide a new strategy for influencing quality of care.

The work carried out under the current QA contract only begins to address quality in the private sector. The contractor shall continue to develop these regulatory strategies, incorporating ongoing advances in developed countries and the results of field evaluations.

F. The Components of Human Resources Management:

Experience under the current QA contract suggests a number of quality issues related to the organization and management of personnel in health programs. In order to address these issues, the contractor shall provide expert assistance in the field of human resource management and planning, including the components listed below. The contractor's program in this field will emphasize research and technical assistance in a limited number of HRM issues where short-term improvements appear to be most feasible.

The contractor shall use operations research and pilot level interventions to expand the very limited empirical basis for HRM in developing countries. By documenting the impact of specific improvements in HRM, the contractor shall provide objective data to address political issues that have hindered progress in this field. Because similar HRM issues are widely shared, the research program will include similar studies in multiple countries to produce a convincing evidence base.

In addition to the research program, the contractor shall also provide technical assistance in a broader range of HRM issues, to the extent that these issues are connected to quality improvement.

The general areas for which the contractor shall provide expert assistance include:

1. Supplying the appropriate staff for the needs of the system: While labor represents about 75% of a health system's total budget, there are many different ways to spend this money. The system's capacity to respond to health needs is affected by what categories of workers are hired, what each type of worker does, and where they work. Poor planning in this area creates a structural inefficiency that is difficult to measure, but probably affects the quality of all services. Frequently, a basic problem is weak coordination between service delivery and human resource managers.

There are many constraints on rational planning, including the political influence of various professional groups, and the complexity of dealing with multiple provider

organizations. However, there are also practical strategies that are often neglected, including: 1) job descriptions that expand the role of less costly staff; 2) inducements to retain staff with good performance, such as career development opportunities; 3) more effective management systems for deployment and utilization of staff; 4) use of transparent criteria, based strictly on need, for recruitment; and 5) identifying feasible improvements in working conditions.

2. Systems to manage performance: The potential role of HRM in the quality and efficiency of health services is poorly developed. For example, quality is lowered when public sector providers are absent during scheduled clinic hours. To increase accountability to consumers, managers need reliable information on staff's time and attendance. Local managers also need a well-defined system for objectively assessing performance, and the authority to provide incentives. Recent quality improvement initiatives generally have been developed outside of the formal system for HRM. In principle, however, these two approaches are complementary: QA provides methodologies for monitoring and improving performance, while systems for performance management institutionalize QA and provide incentives for improvement activities.

Information on performance should also guide training efforts, based on need (see below.)

3. Personnel administration that supports service delivery: Much of health care quality depends on the morale and motivation of providers. Since HRM directly affects the personal welfare of staff, it can complement other quality initiatives. Poor labor relations, on the other hand, can undermine all services.

Broader civil service reform, such as salary levels, is beyond the scope of this project, but there are other opportunities for improvement, such as: 1) Managers could explicitly design conditions of service for personnel, including incentives for remote postings, to promote quality of care. 2) Promotion and career structures should be used as incentives for performance, based on transparent and realistic criteria for quality. 3) Effective management systems for salary payments and benefits may be a prerequisite for many quality interventions. 4) Increased participation by employees in personnel decisions could be linked with quality improvements.

4. Education and training that is integrated with service delivery: Training is necessary for health care, but also potentially wasteful. Many ministries of health have not developed a strategy to shape pre-service and in-service training according to system needs and measures of quality. Efficient use of training resources requires cooperation among the ministry of health and the education ministry, educational institutions and other service providers.
5. Give human resources appropriate emphasis in the overall planning and management of the health system: It is common for policymakers to treat HRM as an area of secondary importance, only weakly linked to health services. The HRM unit is typically staffed with managers that have few specialized skills and a lower rank. And as outlined above, human resource management processes are rarely well defined and transparent. More professional management and the authority to go with it are needed. Research and evaluation is needed to provide the evidence that supports such a change in policies.

- F. Financing: USAID estimates that approximately \$48 million will be available over the five-year duration of this contract to accomplish the objectives described below. For purposes of preparing proposals, bidders should assume that the Bureau for Global Health (BGH) will provide \$15 million of the total amount. The remaining \$33 million will be provided by USAID field missions and regional bureaus, primarily through the Agency's field support mechanism. BGH funds are to be used chiefly for contract objectives related to research and technical leadership. Field support funds are designated for specific geographic areas, usually a country, and may have a defined technical focus, such as HIV/AIDS.

For purposes of preparing proposals, bidders should assume that 80% of the level of effort (LOE) will be devoted to QA activities and 20% to HRM. Of the HRM component, 75% will be related to research and evaluation activities and 25% to technical assistance.

USAID anticipates a cost plus award fee contract: USAID intends to provide an award fee only with no base fee. The fee assessment will be conducted on an annual basis and will be tied to the Contract Performance Report required in accordance with FAR part 44.

G. Objectives of this Contract:

1. Institutionalization of Quality Assurance within USAID-assisted health programs: The contractor shall provide long-term technical assistance to approximately 10 health programs to establish modern quality assurance on a large scale as an integral component of health care. **By the end of the five year period, the contractor shall document improvements for each of the QA elements described below, which meet or exceed the contract objectives listed.**

Health programs in developing countries have traditionally included activities that address quality of care to some degree. Based on the assistance of the current QA contract and other recent initiatives in this field, modern QA strategies such as those outlined in Section C have been introduced in a number of countries. A major objective of this contract is to 1) expand the scale of QA initiatives, 2) increase the range of specific QA approaches applied, and 3) improve the effectiveness of QA programs.

The sub-objectives that contribute to the institutionalization objective include those listed below. **For purposes of determining the annual award fee, overall, quantitative performance indicators are identified for each sub-objective. At the beginning of each award fee period, the CTO will provide technical directions with more specific, weighted evaluation criteria, based on these indicators.**

- a. Policy level commitment: The contractor shall develop a program to educate senior health managers on the rationale for QA and assist them in their role in organizing and supporting this new set of activities. Evidence of such

commitment include explicit, written policies that mandate QA activities, provision of resources for these activities, arrangements for monitoring the QA program, and ongoing management actions in support of quality objectives, including human resources management.

Contract objective: Eight programs will develop written policies addressing QA activities and document management actions to implement these policies.

Performance indicators: number of seminars conducted for managers; policy guidelines produced and distributed; programs issuing or updating QA policies; comprehensiveness of policies; documented management actions in QA and HRM

- b. Organization of QA as an accountable program: The contractor shall support the development of well-defined QA programs that can account for the resources used in QA activities and for the results they produce. Although large QA programs may have full time dedicated staff, the bulk of QA work is carried out by service providers and support staff, who also provide health care. Like other complex activities, an effective QA program requires provision for components such as planning activities, defining roles, keeping records, and transferring skills.

Contract objective: Seven programs will produce comprehensive documentation of the organization of QA activities.

Performance indicators: number of programs with written strategic plan; strategic plans which specify staff roles in QA; programs with documentation of QA activities; programs with documentation of QA training and competencies

- c. Training in QA methods: The contractor shall support the development of sustainable training strategies to meet the needs of these programs for skills and knowledge in QA approaches. These strategies should include the QA components outlined in Section C. In addition, the training approach should be able to accommodate new developments in QA. Training related to HRM interventions should also be included in the approach. The contractor shall support pre-service training in QA in addition to in-service. All QA training will incorporate actual experience in developing countries where feasible and appropriate. **In coordination with the research component (see below), the contractor shall develop innovative training applications, including computer-based training.**

Contract objective: The contractor shall develop a comprehensive set of core training courses, suitable for local adaptation, addressing each of the QA elements outlined in this statement of work. Two long term assistance programs will include large scale application of computer-based training or other distance learning strategies.

Performance indicators: comprehensiveness of model courses produced; proportion of courses incorporating HRM and new QA techniques; average number of developing country case examples per course; number of pre-service curricula in QA introduced

- d. Quality of care monitoring: The contractor shall develop and support practical strategies for monitoring the quality of health care, with emphasis on compliance with evidence-based clinical guidelines, but also addressing patient satisfaction with care, and administrative support for care.

These strategies will incorporate current knowledge related to direct observation of care, self reporting, clinical vignettes, competency testing, provider and client interviews, surrogate patients, improvements of clinical records, and clinical audits. The contractor shall also develop strategies for analyzing and using monitoring data for QA activities, policy development, and reporting.

Contract objective: Eight programs will produce monitoring data with at least three distinct measurement points, and each of the monitoring methods listed will be applied in two programs.

Performance indicators: number of programs with written processes for monitoring quality of care; average number of monitoring methodologies used; programs with documented applications of monitoring data

- e. Development of quality standards: The contractor shall assist host country counterparts to systematically develop and communicate clinical standards, including methods for evaluating and refining the standards. The development process will incorporate current knowledge regarding provider participation, the role of technical leaders, and adjustments for feasibility.

In selecting clinical topics to address, the contractor shall emphasize USAID health priorities, which currently include basic child health services, essential obstetrical care, basic neonatal services, HIV/AIDS, tuberculosis case management, malaria, and reproductive health/family planning. Clinical standards include preventive as well as curative services, interpersonal communications, and services provided in the community.

Contract objective: In seven programs, the contractor shall support and document the development of an evidence-based clinical standard and the corresponding clinical guideline.

Performance indicators: number of systematically developed clinical standards addressing USAID health priorities; level of documented provider knowledge of standards

- f. Promotion of compliance with clinical guidelines: The contractor shall support the development of management strategies to encourage providers to follow clinical guidelines. These strategies will incorporate current knowledge related to

performance feedback, self- and peer assessment, managed incentive systems, human resource management, human performance technology principles for job aid development, more cost-effective training methods, and competency testing. Well-defined quality improvement methodologies will also be incorporated, as discussed below.

Contract objective: In nine programs, the contractor shall document the application and results of methodologies to promote compliance, including three or more methods in each long-term program.

Performance indicators: Number of programs with documentation of provider compliance levels; average levels of provider compliance; average number of compliance promotion methodologies employed

- g. Quality improvement: The contractor shall support the application of appropriate, well-defined approaches for improving the quality **and efficiency** of care, including 1) identifying specific quality problems, 2) analyzing their cause, 3) developing potential solutions, and 4) testing those solutions. Quality improvement applications will include both clinical care and the underlying health system activities that support patient care.

These applications will incorporate current knowledge of quality improvement, including team-based process improvement, more streamlined approaches to problem solving, and specific tools for analysis, presentation of data, and decision making. In addition to principles adapted from developed country applications, the contractor shall incorporate experience from quality improvement in developing and middle income health programs.

The contractor shall also support quality improvement applications in which 1) multiple teams address a similar quality issue in a coordinated initiative; 2) teams are directed to address a specific quality issue, and 3) teams at higher administrative levels address strategic and policy issues, including HRM problems.

Contract objective: In nine programs, the contractor shall provide documentation of the application and results of at least 10 quality improvement interventions.

Performance indicators: number of documented, complete cycles of team-based quality improvement; proportion of cycles at district level or higher; number of documented, appropriate applications of rapid problem solving techniques; proportion of applications that are directed

- h. Benchmarking of best practices: The contractor shall support the development and application of a well-defined methodology for documenting best practices in health programs. This methodology shall incorporate current knowledge regarding the description of health care processes and their relationship to other components of the health system. Application includes implementing the best

practice in another setting, measuring changes in performance, and analyzing obstacles to adopting the best practice.

Contract objective: In five programs, the contractor shall support the application of a standardized methodology for documenting a best practice, the introduction of the best practice into a new administrative unit, and the evaluation of the results.

Performance indicators: number of documented benchmarking applications; proportion with evaluated implementation of the selected best practice

- i. Quality design or re-design of systems of care: The contractor shall develop guidelines for counterparts for re-organizing a component of their program to facilitate higher levels of quality. These guidelines will incorporate current knowledge of how administrative support systems can be purposefully changed to support compliance with clinical guidelines. These guidelines shall also incorporate knowledge related to factors outside the formal health system, which can be modified to support compliance. These guidelines will incorporate examples of re-design applications from developing and middle income countries.

The contractor shall also support the application of these guidelines by host country counterparts, including their evaluation and refinement.

Contract objective: In seven programs, the contractor shall support, document, and evaluate the re-design of a system of care. At least two applications will address HIV/AIDS-related care.

Performance indicators: submission of guidelines with documented field test results; number of documented counterpart applications of guidelines

- j. Documentation and dissemination of quality assurance activities: The contractor shall support development of written documentation and dissemination of QA activities as a standard component of institutionalization. The contractor's documentation approach shall incorporate current knowledge related to the feasibility of record keeping in different settings, the role of quantitative measurement in QA applications, and the types of documentation most conducive to wider application of a given experience. The contractor's approach to disseminating QA activities shall incorporate current knowledge regarding applications of QA experiences within the same program, applications in other programs and countries, the accumulation of worldwide experience in QA, and the incentive value of disseminating QA results.

Contract objective: In at least 10 programs, the contractor shall support the consistent documentation of QA activities and the systematic dissemination of selected written results to providers.

Performance indicators: number of case studies with quantitative results; number of distinct clinical and administrative topics addressed; extent of documented dissemination to counterparts; number of documented applications of cases in other settings

- k. Incentives for performance: The contractor shall support the development of strategies to provide incentives for provider behavior conducive to quality. These strategies shall address incentives related to compliance with clinical and administrative guidelines, including achieving patient satisfaction, and participation in QA activities. These strategies shall incorporate current knowledge of human resource management, performance measurement, and the effective use of material and non-material incentives.

Contract objective: In six programs, the contractor shall support the introduction of performance-based incentives for quality-related work. In at least three applications, the incentive will have material value.

Performance indicators: Number of programs implementing performance-based incentive systems; proportion with documented evaluations

- l. Community demand for quality: The contractor shall support counterparts to identify and respond to the needs of the populations they serve. The contractor's approach shall address facilitation of organized community participation in strategic planning, measuring and responding to patient satisfaction with services, and education of consumers regarding technical and interpersonal elements of quality of care.

Contract objective: In four programs, the contractor shall support the ongoing monitoring of patient opinions regarding health services and the corresponding management responses. In two programs, the contractor shall support the development and evaluation of organized community participation in the governance of health facilities.

Performance indicators: Number of programs which monitor patient satisfaction; proportion with documented management response to monitoring; proportion with community participation in governance; proportion with consumer education activities for quality of care

- m. Monitoring and evaluation of QA programs: The contractor shall support development of systems to routinely monitor the performance of QA programs. The contractor shall also support the design, implementation, and analysis of periodic, in-depth evaluations of QA programs. The contractor's approach shall incorporate current knowledge related to measuring the results of QA activities, describing the process that produced the observed results, and applying this information to management and design decisions, including consideration of the relationships between cost and quality.

Contract objective: The contractor shall design and conduct eight evaluations of large-scale QA programs, including second evaluations in three programs . In six programs, the contractor shall support the design and implementation of management information system for QA activities.

Performance indicators: number of comprehensive evaluations of QA programs conducted and analyzed; number of QA programs with monitoring systems

- n. Regulatory strategies for quality assurance: The contractor shall support applications of the major strategies for the regulation of health care quality through external authorities. The contractor's approach shall accommodate models based on governmental regulatory bodies, private organizations, and models that combine public and private authorities. The contractor's approach shall address programs directed toward individual practitioners, health facilities, specific services of health facilities, and training programs for health professionals. The contractor's approach shall incorporate current knowledge of accreditation, licensing, certification, registration, credentialing, and insurance reimbursement linked to quality measures.

Contract objective: In five countries, the contractor shall support the development of an external, standards-based QA program for facilities, programs, or health professionals. At least two of these programs will address commercial private sector providers.

Performance indicators: number of countries introducing substantially new standards-based quality assurance programs for private sector institutions or providers; proportion with documented improvements in quality measures

2. Short Term Technical Assistance: The contractor shall support international and developing country health organizations to apply QA approaches through short-term technical assistance. The contractor's approach shall cover all of the technical areas discussed for long term technical assistance. As illustrated below, short-term technical assistance is characterized by a limited scope, which is primarily focused on transferring QA approaches to other organizations for implementation. Anticipated requests for short-term assistance include:
- a. Participation in USAID project design teams;
 - b. Support for QA activities within the programs of USAID cooperating agencies, international organizations, and private voluntary organizations;
 - c. Training in specific QA topics for technical advisors;
 - d. Quality of care assessments for USAID-assisted programs;
 - e. Evaluation of established QA programs;
 - f. Introductory seminars on QA and HRM for policymakers;
 - g. Benchmarking studies of selected best practices or programs;
 - h. Development of case studies in QA or HRM.

Contract objectives: The contractor shall provide 10 consultations for international bank projects, 15 consultations for USAID cooperating agencies and other international organizations, 5 policy level seminars on QA and HRM, and develop at least 15 case studies with quantitative results.

Performance indicators: Number of funded and non-funded requests; standardized evaluation form ratings

3. Operations Research: The contractor shall develop a program of operations research to adapt QA and HRM approaches to the needs of developing and middle income countries. The majority of core funds provided by the Bureau for Global Health (BGH) shall be used for this program. Each core-funded study shall include an explicit connection to BGH priorities, as outlined in Bureau strategy papers and other official documents. Current priorities are summarized above and can be found at http://www.usaid.gov/pop_health/

For the purposes of this contract, operations research is interpreted broadly to indicate a systematic effort to generate knowledge that would not be generated by ordinary program activities. Research methodologies may include intervention studies, descriptive research, pilot demonstration projects, and reviews of available data and reports.

The contractor's research strategy shall incorporate an assessment and prioritization of research needs in QA and HRM, and demonstrate cost consciousness in the design of research activities. The strategy shall include a knowledgeable review of the most relevant research in these areas, major research issues remaining, and the major active research programs outside this contract. The strategy shall also outline potential collaborations to increase the productivity of limited contract research funds, including those with other research programs, with ongoing QA programs, and with focused service delivery initiatives.

The contractor's research strategy shall address the following technical areas, which raise additional considerations related to USAID's comparative advantage, priority topics suggested by the experience of the current contract, and the needs in QA/HRM projected from recent developments in the USAID health program:

- a) evaluation of different methods and combinations of methods for monitoring quality of care;
- b) evaluation of alternative approaches to increasing levels of compliance with clinical guidelines;
- c) development and refinement of more cost-effective strategies for quality improvement
- d) development of approaches to building the capacity of counterparts to design systems of care conducive to high levels of quality;
- e) evaluation and refinement of strategies to build counterpart capacity to apply the principles of human performance technology to the design of job aids;
- f) evaluation of different uses of computer-based training and distance learning strategies;

- g) assessment of strategies to provide performance-based incentives for providers and administrative personnel;
- h) development of standards-based evaluation strategies for QA, suitable for application to private sector providers, programs, and facilities;
- i) expansion of the evidence base for human resources management, with emphasis on quality-related issues;
- j) study of the relationships between cost and quality;
- k) evaluations of the organization, performance, and impact of QA programs.

Contract objectives: The contractor shall conduct 50 distinct research studies, including at least 15 that address human resource management issues.

Performance indicators: proportion of priority topics addressed; number of studies approved and completed; average cost; level of mission funding; number accepted for publication or presentation

4. Technical Leadership: The contractor shall carry out a range of activities, in addition to technical assistance to programs and research, to promote the application and advancement of knowledge in QA and HRM through other international organizations. Illustrative activities include: 1) participation in professional meetings; 2) preparation and dissemination of technical papers; 3) publication of papers in professional journals; 4) participation in international panels, committees, and evaluation teams; 5) consultations with donor organizations, non-governmental organizations, and other USAID-funded cooperating agencies; 6) development of training activities for international organizations; 7) development of training courses and tools designed for application by other organizations; 8) the use of electronic media to inform international organizations; 9) consultation with academic training centers; 10) briefings for journalists; and 11) training activities to develop new competencies among the project staff.

Performance indicators: number of invited presentations at international meetings; number of technical documents disseminated; size and appropriateness of distribution; number of consultations and training activities for international organizations; proportion of repeat requests

- H. Country Selection: Contractor services shall be available on a worldwide basis. Programs for long-term technical assistance will be selected from countries in which USAID is represented. In consultation with USAID missions, the CTO will provide technical directions to identify countries and programs for long-term assistance. USAID non-presence countries will be eligible for short-term assistance and research activities, subject to CTO technical directions. For purposes of preparing proposals, bidders shall assume that the long-term assistance countries will comprise two in the LAC region, one in E&E, two in ANE, and five in Africa.
- I. Personnel: Bidders may propose the staffing pattern that they regard as optimal to complete the statement of work, including use of part-time staff, host-country and third-country nationals, and consultants. This flexibility also applies to any sub-contractors.

However, the offeror will designate as key personnel those which are regarded as essential to the work being performed.

- J. Small business subcontracting plan: Offerors shall include in their proposals a plan for subcontracting elements of the statement of work to small and small disadvantaged businesses which meet the criteria in 13 CFR Part 121 and 124, respectively. The plan will identify the work to be subcontracted, the firm(s) to be used, and the estimated value of the proposed subcontract.
- K. Required reports: The contractor shall submit two copies (unless otherwise indicated) of the following reports to the CTO, at the time and frequency indicated:
 - 1. Annual work plan: This report shall describe the work to be carried out under the contract for a 12 month period, subject to approval by the CTO and modifications through technical directions; submitted annually, starting within 90 days of the contract award.
 - 2. Annual project report: This report shall summarize the activities and results of the contract for a 12 month period; submitted annually, starting 90 days after the end of the first 12 months of the contract, except for the final 12 month period.
 - 3. Trip reports: This report shall summarize the results of international travel supported by the contract; a single copy will be submitted within 30 days of completion of the travel.
 - 4. Self evaluation report: This report shall summarize the accomplishments, results, and issues for each 12 month award fee period, organized by the performance evaluation areas listed in Section E and specific criteria provided by the CTO; five copies will be submitted within 90 days after the end of the award fee period, except for the final year, when the report shall be submitted 90 days before the end of the contract.
 - 5. Research reports: For each proposed operations research study, the contractor shall submit, for CTO approval, a proposal outlining the research to be carried out, a schedule of activities, and a budget. Upon completion of each study, the contractor shall submit five copies of a report summarizing and interpreting the results.
 - 6. Final project report: Within 90 days of the end of the contract, the contractor shall submit 10 copies of a report summarizing the major accomplishments, results, and findings produced under the contract.